Review of September 25 Meeting

Review of committee work to date. The meeting began with a review of the PHIP charge and the role of the Washington Health Report Card's role in that effort. The Department of Health is already using the Report Card structure and indicators in planning, and is finding it a highly useful tool for targeting resources.

Issues and questions regarding the report card, its implementation and its applications were raised during the discussion.

- It was noted that both indicators and data on indicators will undoubtedly be improved over time.
- It will be necessary to have county level data for the report card to be useful and used across the state. Tobacco money will be used to increase the sample size of the 2003 BRFSS to provide a minimum of 200 interviews per county. Counties can add additional interviews at a marginal cost. An additional 400 interviews (bringing the county total to 600 interviews) would cost approximately $12,000 - $14,000 for a county. An additional 200 interviews would cost about half that amount. Only CDC core questions are covered in this estimate, but that does include the behavior questions, which are the biggest health determinants. Additional county level interviews would provide excellent baseline data with respect the report card. (***This information will be posted to counties and disseminated through assessment coordinators so that counties can act quickly to identify funding sources to take advantage of the county level sampling frames for the 2003 BRFSS***).
- ***Committee members had become more comfortable with the sources that surfaced regarding the relative determinants of health—***
    - ***10% health care delivery***
    - ***20 – 30% genetics***
    - ***20% environment***
    - ***40 – 50% behavior***

Report Card Stakeholder Issues and Refrains, Round Two. An additional round of stakeholder interviews was conducted including two from the business community, two from education, one from a religious community, one from a local community group, and one from the health system. Five of the stakeholders were from the Spokane area, one from the Vancouver area, and one from the Olympia area.

The feedback was similar to that heard in the first round of interviewing. In general, the layout and organization of the report card made sense to stakeholders. Few were surprised by the significant role played by behaviors and the environment, but some thought that certain audiences, such as employers, might be quite surprised at the relatively small weight attributed to the health care system. One person expressed concern that the small weight accorded to the health care system might suggest to policy makers that they need not fund health services.

As we heard previously, additional indicators were suggested, including child care, housing, and drug use (especially methamphetamine production/use). The relationship of some indicators (e.g., poverty) to health care was not readily understood by all. (***Committee members noted that materials accompanying the report card will need to explain those relationships. In addition, the materials will need to emphasize that the indicators are meta-determinants, based on science***). Bio-terrorism did not surface in the discussions as a key indicator or determinant of health.

Stakeholders were pleased that the development of and audience for the report card was broader than public health and the health care system. Including employers as a key audience is critical.

In this round of interviewing stakeholders were specifically asked about the "readiness to learn" label with "healthy child development" and "early child development" provided as possible substitutes. The measure "successfully completes kindergarten" was also raised with stakeholders. Shareholders liked the broad concept of childhood development, but varied in there assessments of labels. Stakeholders were not entirely satisfied with successfully completing kindergarten as a measure. (***Committee members determined that the label will be Healthy Child Development. We will work with OSPI over time to develop a better measure).***

Stakeholders noted that information about intervention strategies is needed to make the report card useful. The materials should be designed by marketers. Community groups and leaders can help disseminate materials. Stakeholders urged that materials be kept simple. Details should be available for those who want to look them up, but should be kept separate from the report card.

Report card and baseline data. A few changes were made to/incorporated into the report card. In addition to "Healthy child development" (replacement for readiness to learn), environmental items became:

- "Illnesses commonly associated with unsafe food, unsafe water or poor hygiene"
- "Safe drinking water"

Behavioral items were changed to:

- "Do we smoke cigarettes?"
- "Do we eat fruits and vegetables?"

Baseline data were presented for most of the indicators, along with charts, titles and brief text to describe the indicator and data. By and large, the charts representing the data worked well. The following changes are to be made in the next iteration:

- ***Make the titles to the charts more conversational—a sound bite about the data.***
- ***Keep the charts simple—e.g., combine men and women for years of healthy life.***

- ***Where there is likely to be variation (e.g., implications of double the poverty level will vary by region), note that in the text. Note "double" poverty rate in the title.***
- ***Make zero the bottom of the y-axis for all charts***
- ***Represent the healthy perspective in the charts--% that don't smoke rather than % that do smoke***
- ***Check to see if teenager perpetrators are included in domestic-violence related offenses***
- ***Include a placeholder for indicators for which we have no data.***
- ***Keep the text non-technical; put technical discussion elsewhere***

Interventions. We want to direct people to interventions with proven pay-offs. The level of investment in interventions with proven pay-offs has not been great. We need to put it into context—e.g., 1 in 10 adults are mentally distressed—what would it take to cut that rate in half? We will not always have the answers to the cost/benefit questions, and in fact, we might not always have evidence about proven effectiveness. But the interventions included either must have proven effectiveness or at the very least, based in sound theory. There is more evidence regarding interventions around individual behaviors than on some of the environmental indicators.

The intervention product for the tool kit should be organized as a matrix with each indicator listed on one axis (possibly including data on the indicator, the local target if one is set, and an explanation of the relationship of the indicator and health) and various levels of intervention on the other axis as follows:

- Community
- Employer/workplace
- School
- Individual/family
- Health care providers
- Public health

The tool should emphasize a comprehensive, multiple action approach. It should give examples of how a specific intervention gets started and who gets involved.

The Community Guide is a set of recommendations regarding population-based interventions for a variety of public health topics including tobacco product use, alcohol abuse, physical activity, vaccine preventable diseases, mental health, motor vehicle occupant injury, violent and abusive behavior, and the sociocultural environment. Other areas will be addressed in the future, including promotion of healthful diets. The recommendations are based on proven effectiveness. Recommendations have been made for tobacco use, physical activity, vaccine preventable diseases, motor vehicle occupant injury and sociocultural environment. Recommendations for other areas are due in 2003.

How to set targets? Another product in the tool kit is a piece that deals with the value and process of setting local targets—what are the goals and what will it cost to get there? We want it kept simple and non-technical.

This piece needs to also exhort folks to evaluate their efforts as one component of the intervention. When the intervention chosen is evidence based, it is probably enough to just ensure that the indicator(s) are moving in the right direction. When a less proven intervention is chosen, a more extensive evaluation is called for.

Next steps. The PHIP report is being written, and the report card summary will be a four page chapter within that report. A key part of the PHIP report is recommendations about how to keep the report card going.

The more detailed work will be included in the tool kit, and in additional back up information (technical supporting information and links to related information, such as what other states and communities are doing). The tool kit will consist of:

- The report card—one page
- Indicators—12 more detailed pages about how they contribute to health
- A matrix showing interventions
- A piece on targeting/evaluation

We will begin to review tool kit information at the next meeting and continue to work on it the rest of the year and into the beginning of next year.

We need ambassadors for the tool kit/report card. The assessment coordinators can help play this role as can partners in PHIP. A training program is needed for ambassadors to show how the tool kit can be used/useful so that they are well-schooled and can infect the community. Local boards of health might be enlisted. Training sessions for legislators and staff would be useful. The messages are "How do we make smart decisions?" "Don't settle for less than smart decisions and good investments."